PHYSICIANS PARTNERING WITH PATIENTS

STATEMENT OF

PHYSICIANS for FAIR COVERAGE

ON

THE IMPACT ON ACCESS TO CARE OF A BAN ON BALANCE BILLING WITHOUT AN INSURANCE REIMBURSEMENT REQUIREMENT FOR UNEXPECTED OUT-OF-NETWORK MEDICAL CARE

THE SENATE COMMITTEE ON HEALTH CARE
OREGON STATE LEGISLATURE

FEBRUARY 12, 2018

On behalf of nearly 300 physicians in the State of Oregon who are members of Physicians for Fair Coverage (PFC), a national, non-profit, non-partisan, multi-specialty organization of more than 70,000 physicians nationwide advocating to end surprise billing and protect access to care, we respectfully submit this statement for the record to the Oregon Senate Committee on Health Care.

As the Committee is aware, a ban on balance billing will be implemented on March 1, 2018, as required by HB 2339 when enacted last year. While we agree this is an important patient protection to reduce individual health care costs associated with unexpected out-of-network care, we are extremely concerned there is no minimum reimbursement standard in place to ensure fair and reasonable payment for the physicians who care for them.

Left unaddressed, health plans could use the ban on balance billing to unilaterally lower reimbursement with those providers who have no legal or ethical choice but to care for the payer's beneficiaries who present with an emergency.

Further, there will be no incentive for health plans to contract with providers or offer reasonable contract rates -- *unless they are also held to an adequate payment standard for out-of-network services*. Insurers will tell you that reimbursing at a

higher rate for unexpected out-of-network care than for in-network care will lead to doctors preferring to be out-of-network. This is completely false.

To be clear, the overwhelming majority of physicians prefer to be in-network. Doing so means higher patient volume, greater referrals, lower administrative costs, fewer denials, and guaranteed payment.

Unfortunately, insurers are already taking advantage of the ban on balance billing and refusing to negotiate in good faith with their current in-network providers. In one very recent example, CEP America – in a January 18, 2018, letter to the Oregon Department of Consumer and Business Services – cites how one insurer offered them 25 percent less to provide emergency services in 2018 knowing that if they refuse, CEP America will be forced out-of-network and subject to whatever the insurer decides to pay with no ability to balance bill for the difference. This despite a continued increase in the cost of providing care. The letter states:

> "*As an example, CEP America has been contracted with a large health plan in Oregon at a reasonably discounted rate. Following the passage of HB 2339, the health plan attempted to renegotiate a rate that was 25% lower than CEP America's existing contracted rate. The health plan specifically cited HB 2339 as the reason for reducing the contracted rates. Since there is no payment standard established for out-of-network service, the health plan was able to make unreasonable demands for contracted rates. Although HB 2339 was passed to ban balance billing for out-of-network service, the consequences of not having an adequate payment standard will be inadequate payments for both in-network and out-of-network services.*"

While unexpected out-of-network care can occur in any setting and be provided by numerous different specialties, it is most prevalent in emergency services and rural areas. Emergency services is the jewel of the American healthcare system, providing uniform excellence in all settings with 24/7 365-days-a-year service. Rural areas have limited medical capacity, often lacking a choice of needed specialists (such as cardiologists or orthopedic surgeons) with the only access to non-emergent healthcare – as well as emergency services – sometimes many miles away.

Maintaining emergency services capable of handling medical and traumatic emergencies, as well as surge capacity, on a 24/7/365 basis is very expensive. Uncompensated care accounts for approximately 25 percent of emergency services. Taxpayer funded government support from programs such as Medicare, Medicaid, Veterans Health, and Workers Compensation has gradually decreased in recent years to a point that payments no longer cover pro rata costs of emergency care, approximately 50 percent of emergency services.

Furthermore, co-payments and deductibles are not generally collected for emergency services. Unlike most office practices, the collection rate for emergency services is less than 40 percent.

Notably, if a health plan provides adequate networks and compensation for services, then balance billing is not necessary. Some health plans intentionally provide narrow networks so that patients are likely to require out-of-network service with reduced out-of-network reimbursement. *By doing so, the cost of providing care is shifted to the patient and providers.*

In many cases, patients are unable to afford the cost-sharing requirements for unexpected medical care which can also place a financial burden on providers. As community employers, the combination of increasingly lower reimbursement rates coupled with more uncompensated care can negatively impact physician practices' ability to retain nurses, nurse practitioners, physician assistants, and other staff needed in order to best serve their patients.

When establishing a ban on balance billing in Oregon, there should also have been a minimum reimbursement standard set, especially to allow for the continuation of resources necessary to at the very least maintain emergency services. It would also, of course, allow rural areas to retain – and even attract – physicians to their communities, especially to keep rural emergency room doors open. The same is true for those areas with a high prevalence of uncompensated or undercompensated care.

As documented by the Portland Business Journal in a November 28, 2017 article, health insurers in Oregon have seen a significant increase in profits since 2016. This while narrowing networks and increasing premiums for consumers (on average by 14% in 2018), as well as for small businesses (nearly 7% in 2018). Deductibles and cost-sharing for patients also continue to increase while reimbursements to care providers decrease.

Noting that the Advisory Panel established by HB 2339 – on which PFC holds a seat – failed to reach agreement on a fair and reasonable reimbursement standard by the deadline, ***it is absolutely critical that an interim minimum reimbursement standard be established for care provided after March 1 (when the ban is effective) in order to ensure the continuation of access to care***. Not having an interim standard in place on March 1 could undermine the stability of the state's emergency and rural care safety net. Additionally, putting an interim standard in place now allows the Advisory Panel to continue its' important work.

To be certain, the interim standard should be higher than the approved amount for services to take into account the disadvantages physicians encounter when unexpectedly treating out-of-network patients. While the Advisory Panel continues its' work, such a standard also incentivizes insurers to negotiate in good faith to bring physicians in-network to best serve their beneficiaries.

PFC urges the Members of this Committee to consider an immediate measure to ensure fair payment for providers who unexpectedly care for out-of-network

patients beginning March 1, 2018. Doing so is absolutely critical to maintaining access to care in Oregon.

Thank you for your consideration. We stand ready to assist you with this very important matter.